



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MANUEL RAMIREZ, M.D.
9080 HARRY HINES STE 110
DALLAS, TX 75235

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TWIN CITY FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-09-8495-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary from Table of Disputed Services: "INSURANCE CARRIER DENIED CLAIM FOR TIMELY FILING. SEE ATTACHED CORRESPONDENCE SHOWING CLAIM WAS SENT TO CARRIER WITHIN THE FILING LIMIT."

Amount in Dispute: \$184.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Did not comply Rule 133.2(2), 133.20(b), 408.027(a). Corrected billing not rec'd until 3/5/09-over 95 Days"

Response Submitted by: The Hartford, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2008	99243	\$184.08	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §133.10 sets out health care provider billing procedures.
4. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.

5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 17, 2009

- The time limit for filing has expired. Per Texas Labor Code 408.027 bills must be sent to the carrier on a timely basis. Within 95 days from the dates of service.

Explanation of benefits dated April 30, 2009

- W1- WC State Fee Schedule adjustment. Reimbursement for your resubmitted [sic] invoice has been considered. No additional monies are being paid at this time.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with 28 Texas Administrative Codes §133.10(d), §102.4 and Texas Labor Code §408.027?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part “Except as provided in Labor code §408.0272...a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” No documentation was found to support that §408.0272 applies to the service in dispute, for that reason, the health care provider and requestor in this dispute were required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.”
2. Review of the documentation submitted by the Requestor finds three copies of a bill dated 11/20/2008, 12/30/2008 and 3/20/2009 in Box 31, a letter received from the Respondent dated 12/17/2008 stating they were unable to process a payment because bill did not contain a valid license number of the referring provider. Although the Requestors documentation supports that a bill was originally submitted to the Respondent within 95 days from the date of service, the bill did not contain a license number in box 17a for the referring physician as required per Version 2.0 of the Texas Clean Claim and Electronic Medical Billing and Payment of Workers’ Compensation Companion Guides and in accordance with 28 Texas Administrative Code §133.10(d) and therefore, the medical bill was returned by the Respondent.
3. Pursuant to 28 Texas Administrative Code §133.20(g), “Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier. “The Division concludes that the insurance carrier properly returned the incomplete bill. No documentation was found to sufficiently support that a corrected bill was submitted to the insurance carrier within 95 days from the date the services were provided.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 14, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.